



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

REZIK SAQER MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-15-0873-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

November 10, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is to state that Rezik A. Saqer, M.D., is an Anesthesiologist specializing in Pain Management When a patient comes in for the first time for evaluation, a random drug test is performed in our office to determine if the patient is on narcotic medications or if there is any illegal drugs in the patient's system. The patient signs a narcotic contract with our facility and only uses the Pharmacy listed on that contract. The patient understands when signing this contract that if they violate any of the terms of their contract his will result in the termination of the patient/physician relationship ... We have attempted to work with Texas Mutual Insurance Company in resolving this issue. We have been denied payment for the qualitative testing performed in our lab. We do the qualitative portion of the screening because we write out narcotic refills for our patients the same day and the immediate result from this test determines the patient's compliance or non compliance. As you can see from the attached EOB, we were denied payment because submitted documentation does not support the service being billed and ODG documentation requirements for urine drug screen testing have not been meet ... Texas Mutual Insurance does not deny all of our patients claims for RDS. I am sending samples of several blacked-out copies of cases we appealed and payment was issued, in one case even interest was paid."

Amount in Dispute: \$280.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has waived its right to dispute resolution because the filing was late. The requestor did not file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307. Therefore, the requestor waived its right to medical fee dispute resolution ... This dispute does not involve a compensability, extent of injury, liability, or medical necessity dispute. Accordingly, the dispute was required to be filed no later than one year after the date of service in dispute. This request for Medical Fee Dispute Resolution was filed on 11/10/2014 and the date of service in dispute is 7/12/2013. Thus, this filing is more than one year after the date of service in dispute."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2013	CPT Code G0431	\$280.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MSUT BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
 - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
 - 758 – ODG DOCUMENTATION REQUIREMENTS FOR URINE DRUG TESTING HAVE NOT BEEN MET
 - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPELY
 - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is July 12, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 10, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

3/6/15

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received

by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.